JUSTICE ADMINISTRATION DEPARTMENT

HARRIS COUNTY, TEXAS

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REPORT

To: Commissioners Court Member
From: Justice Administration Department
Date: August 3rd, 2021
RE: CureViolence (CV), a street outreach program, and Hospital-Based Violence Intervention Programs (HVIPs).

Abstract: Some Harris County residents are at a high risk of being victimized by violent crime. Social science research presents evidence that a small stratum of the population is at risk of perpetrating and being victimized by violent crime. The "public health approach" to violence prevention presents evidence that a highly-targeted approach to reduce violent crime and victimization could effectively address crimes like aggravated assaults and homicides in Harris County. In response to an increase of such crimes, a growing number of jurisdictions across the county are investing in departments that apply the public health a pproach to bolster community safety: Offices of Violence Prevention. This report considers two programs that are commonly embedded in such offices: CureViolence (CV), a street outreach program, and Hospital-Based Violence Intervention Programs (HVIPs), which assist individuals hospitalized after a violent assault to desist from violence and retaliation. Though different in several important ways; these programs intervene to stop cycles of violence and by working with individuals at the highest risk of becoming victimized or perpetrating community violence, specifically as it relates to gun-involved incidents. These interventions meet people where they are at and intervene at critical windows—either on the street in areas most heavily impacted by violence before situations escalate or in the hospital immediately following a violent injury due to community violence). Both programs rely on staff who can credibly relate to the life circumstances and experience of those victimized and connect participants to community resources and social services crucial to reducing individuals' risk of perpetrating and experiencing violence. Both programs are shown to be effective by a growing weight of social-scientific evidence. To that end, this transmittal accompanies two memos produced by prominent technical assistants on the needs, opportunities, and best practices for the implementation of these programs in Harris County. Dr. Chico Tillmon of Tillmon Training and Consulting, Inc. produced the transmitted report on CV; staff associated with the Health Alliance for Violence Intervention (HAVI) produced the transmitted report on HVIPs.

Report Outline:

Background:

- In recent months, violent crime rates have increased both nationally and locally. Rates of homicides and aggravated assaults per 100,000 residents have increased in Harris County (as in other large, metropolitan communities). These increases in violence necessitate policy interventions to reduce that violence.
- Many Americans remain disproportionately exposed to violence. Indicators of community health, social and economic deprivation, and under-investment correlate with violence. Thus, violence disproportionately impacts people of color, especially Black Americans,[1] poor and working-class people,[2] women,[3] and gender and sexual minorities.[4]
- For much of the past 50 years, the predominant policy response to violence was to incarcerate perpetrators.[5] Policymakers are increasingly rethinking this consensus and exploring alternative approaches that seek to interrupt or prevent violence rather than incarcerating individuals after perpetrating violence. Such an approach—which we call here both a public health approach and an emphasis on preventing violence—addresses the root causes that drive violence in disadvantaged communities. There are several reasons for this policy evolution.
    - That focus on prevention will help save lives and stop the cycle of violence.
    - Public health experts are better equipped to implement prevention strategies. Public health experts trained in getting at the root causes of violence means more time for law enforcement to focus on clearance rates and reduce their high burnout.
    - Moreover, a focus on prevention could attenuate some of the unintended consequences of the carceral approach. Extensive research by social scientists have identified the unintended consequences of the carceral approach. Incarceration itself for example exposes individuals to violence,[6] makes those sentenced to incarceration far more likely to violently re-offend than their non-incarcerated peers,[7] shortens the lives of those incarcerated,[8] is associated with higher mortality in entire communities.[9]

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1 (Jackman & Shauman, 2019)
2 (Desmond & Western, 2018)
3 (Crenshaw, 2012)
4 (Flores et al., 2020)
5 (Beckett, 1997; Weaver, 2007; Beckett & Ming Francis, 2020)
6 (Feldman et al., 2016)
7 (Harding et al., 2019)
8 (Rosen et al., 2008; Patterson, 2013)
9 (Kajeepeta et al., 2021)

- Finally, the public health approach has been demonstrated as both effective and cost-effective, as will be discussed below.

- This memo reviews two particularly promising policy interventions to interrupt cycles of violence, and discusses the opportunities and constraints of implementing each in Harris County—fulfilling a Commissioners Court mandate. These two broad families of programs are: (1) **violence interruption and prevention programs** and (2) **hospital-based violence interruption and prevention programs**.

Long and Short Term Crime Trends:

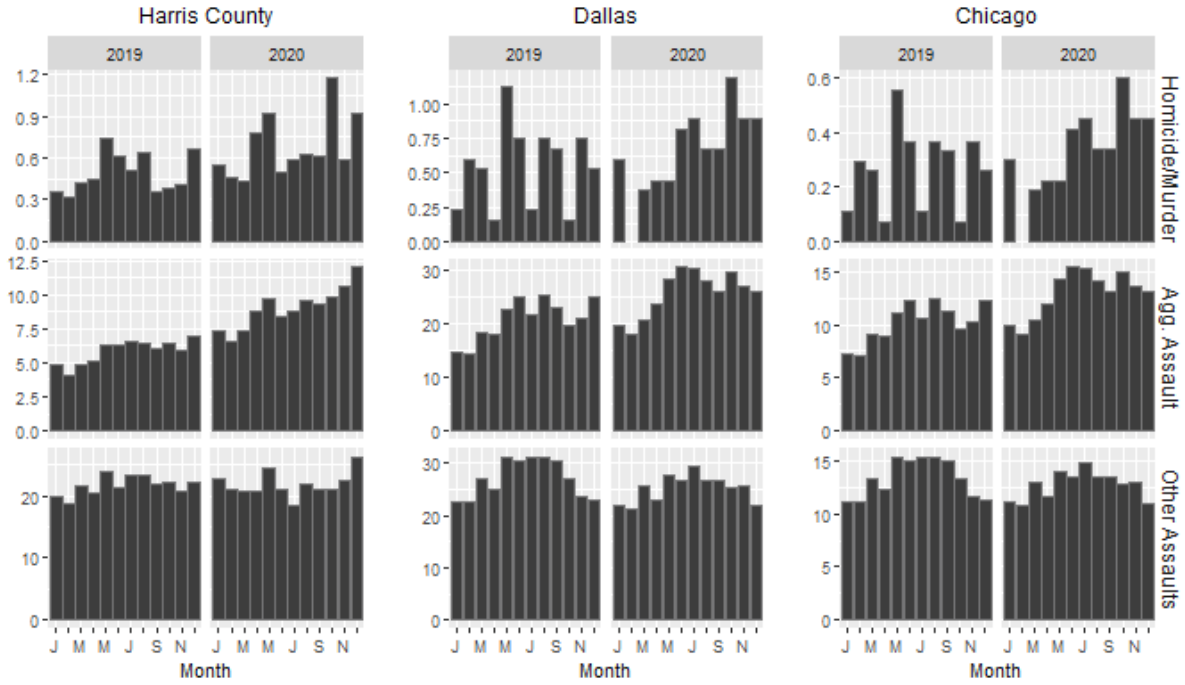

Figure 1: Violent crime trends per 100,000 residents in Harris County and comparable jurisdictions. Monthly counts of criminal cases in Harris County, incidents in the City of Dallas, and cases in Chicago. Year and offense type indicated by facet of plot.

- Violent crime has declined strikingly across the U.S. from the early 1990s until at least 2019 due to several macro-level social changes that are difficult to disentangle. Researchers typically emphasize that the historically large decrease in violent crime in the U.S. can be attributed to changing age demographics, and changes in the economics and structures of drug trafficking organizations.[10] In recent months, violent crime rates have increased locally and nationally. Rates of homicides and aggravated assaults per 100,000 residents have increased in Harris County (as in other large, metropolitan

[10] (Renno & Santos, 2020)

communities). Rates of other (or common) assaults have remained steady or slightly decreased, again, as is the case in other jurisdictions comparable to Harris County. Each of these trends is visualized in **Figure 1**. The fact that these increases occurred simultaneously in several jurisdictions across the country strongly suggests that these trends are attributable to national-level socioeconomic pressures. Nevertheless, increases in violent crimes demand policy interventions for public safety and prevention.

The Public Health Approach:

- Several pathbreaking policy initiatives to reduce violence without involving punitive law enforcement institutions are often grouped under the umbrella of the "public health approach." Researchers of diverse backgrounds and methodologies have shown that interpersonal violence and violent assaults stem from "the same roots" as other forms of violence, such as community violence, child maltreatment, …domestic violence,"[11] as well as self-inflicted violence, and even collective violence, like social, political, and economic deprivation.[12] These similarities have prompted contemporary researchers to explore "the public health approach to violence prevention" which employs four distinct steps to combat violence, which are adapted from the principles undergirding public health initiatives:
  - ***Defining the problem***: or examining data to identify "the 'who,' 'what,' 'where,' 'when,' and 'how' in community violence.
  - ***Identifying risk and protective factors***: or examining the above trends to develop empirical understandings of *why* individuals, groups, or communities are victimized and why others are not. This allows researchers to determine risk and protective factors.
  - ***Develop and test prevention strategies***: where insights for the previous step are employed to identify prevention strategies for the community writ large, by attempting to spread protective factors across the community, and constrain the spread of preventive factors.
  - ***Assure widespread adoption***: by facilitating inter-jurisdictional collaboration, "registries for evidence-based practice," or training and technical assistance, all of which will enable greater diffusion of and innovation in prevention strategies.[13]
- Thus, policymakers and practitioners have implemented numerous innovative programs that adapt public health interventions to address violence.[14] In doing so, collaborative initiatives have developed successful strategies to reduce

[11] (Prevention Institute and Cities United, n.d.)
[12] (Krug et al., 2002)
[13] (See: CDC, n.d.; WHO, n.d.; Educational Fund to Stop Gun Violence, 2021)
[14] Researchers have adapted interventions against motor vehicle violence to combat gun violence (e.g. Hemenway & Miller, 2013).

firearm suicides, intimate partner violence, and childhood maltreatment. These successes, strikingly, are cost-effective, and are accomplished without the above-cited unintended consequences of law enforcement-oriented solutions.[15]

- A burgeoning policy initiative in the US that applies the public health approach institutes Offices of Violence Prevention in various cities. One exemplary such program, in Richmond, CA, "…is housed within the city government and staffed by civilians with no authority to enforce the law. This structure is deliberate: Richmond's ONS (Office of Neighborhood Safety) supports interventions that intentionally operate outside or parallel to the criminal justice system in order to maintain credibility with those at highest risk of violence." That approach, then, "provides a foundation" for the establishment of more concrete and/or targeted interventions to specifically reduce violence. The implementation of those programs can, themselves, have a constructive effect on community violence—the establishment of the Richmond ONS "…was associated with a 55 percent reduction in gun homicides and hospitalizations and a 43 percent reduction in firearm-related crimes." Offices of Violence Prevention are housed outside of law enforcement institutions and directly funded through municipal budgets. In doing so, successful offices balance between formal structure and the employment of those with lived experience who can serve as *credible messengers* (see below).[16]

- Thus, policymakers and researchers have sought to identify a policy intervention to reduce, or *interrupt* cycles of violence without resorting to practices that may entrench cycles of violence.

Community Violence Interruption and Prevention Programs:

- *The Cure Violence Model:* The Cure Violence (CV) model is perhaps the most well-known application of the public health model to combat violent crime in a deprived community.[17] The model was developed by Dr. Gary Slutkin, a physician whose research applied theories of *social contagion* to explain the spread of violence. The underlying paradigm assumes that violence is a human behavior that can be interpersonally communicated. Moreover, like other behaviors, violence responds to socially-transmitted "structures, incentives, and norms."[18] In CV programs, the individuals at the highest risk of repeatedly perpetrating—and being subject to—violence are directly contacted and diverted. Participants in a CV program "must meet at least four of seven criteria: (*a*) gang-involved, (*b*) major player in a drug or street organization, (*c*) violent criminal history, (*d*) recent incarceration, (*e*) reputation of carrying a

[15] For an overview of programs see: American Public Health Association (2018).
[16] (Pearl, 2020)
[17] (American Public Health Association, 2018)
[18] (Butts et al., 2015, p.40)

gun, (*f*) recent victim of a shooting, and (*g*) being between 16 and 25 years of age."[19] These participants—who actually receive the policy "intervention"—are presented with the social norm that CV seeks to enforce: "that violence is harmful to everyone, that it is unacceptable behavior, and that it can be stopped."[20] The universe of potential participants in a CV program is, necessarily, relatively small, for two reasons. First, the CV "theory of change" emphasizes that norms around violence diffuse from a relatively small "hub" of individuals at greatest risk for perpetrating and experiencing violence. As such, the intervention can—indeed should—be directed at this small group. Second, the program requires a tight-knit relationship between participants and staff. These practices are described in greater detail here. The overall structure of the model is depicted in **Figure 2**.

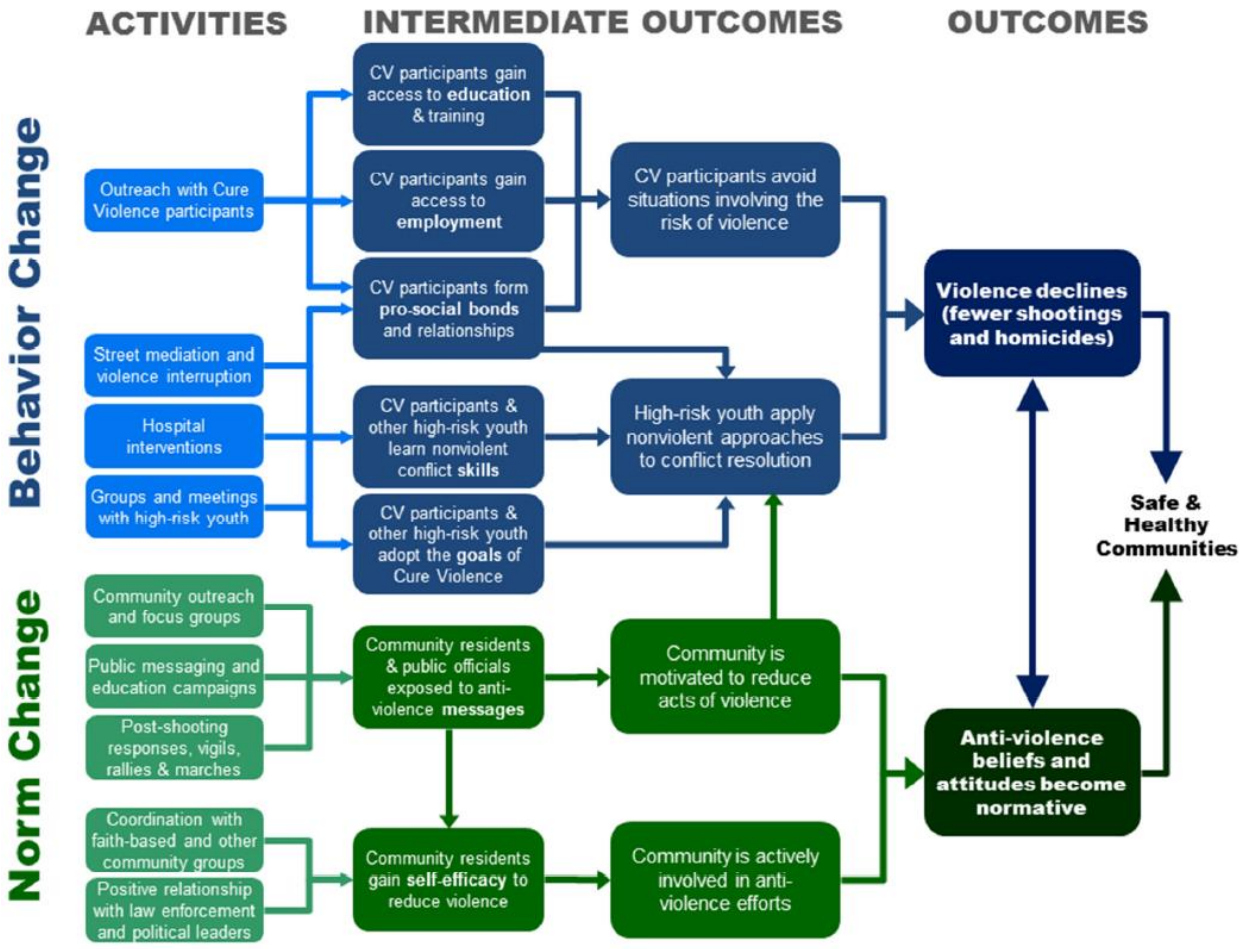

Figure 2: Conceptual model of the structure and function of a CV model. Source: Butts et al., 2013.

[19] (p.40-41)
[20] (p.41)

- *Staffing:* There are two pools of staff in a CV program that help to disseminate that message. The first group is known as violence interrupters (VIs), and the second group are referred to as outreach workers (OWs).
    - VIs are most closely involved with the task of changing social norms around violence, and, as such, are key to the success of the program. "They are hired for their ability to establish relationships with the most high-risk young people in the community, usually young men between the ages of 15 and 30. The VIs form relationships with individuals at high risk of committing violence and monitor ongoing disputes to learn about potential acts of retaliation before they happen. When someone is injured or shot, the victim's friends and peers may seek revenge. The VIs from CV seek out those connected to the victim and try to "talk them down" or persuade them that there are other ways to negotiate the conflict without engaging in more violence that could risk their liberty and their own lives." VIs are essential to the success of the program (see below), and as such, "VIs must be carefully recruited. They need to be seen as credible messengers by the most high-risk young people in the community. Many VIs are former high-level or popular gang members who have changed their lives—often after a stint in prison. They need to know about the daily routines of [participants]… They cannot be judgmental or be perceived as outsiders, and they cannot be seen as police informants. Ideally, they should come from the same communities in which they are working, and they should demonstrate in their own lives and personal conduct that it is possible to be both law-abiding and respected in the neighborhood."
    - As stated above, the second broad group of staff members is OWs. "Outreach workers are similar to case managers. Like the VIs, the OWs need to have trusting relationships with the most high-risk individuals in the community, and it helps if the OWs have also had prior involvement with the justice system. Both the VIs and the OWs need to be seen as credible by young people living high-risk lives." OWs, due to their physical location, training, and life experiences, are less well-placed to actually "interrupt" the transmission of violence. Instead, they help to allay the social pressures and deprivations that continue to place individuals at risk for experiencing or perpetrating violence. Thus, "…OWs use their relationships with program participants to help connect high-risk individuals to positive opportunities and resources in the community, including employment, housing, recreational activities, and education. OWs carry caseloads of up to 15 participants. The central goal of an OW is to facilitate the process

by which potentially violent individuals learn to think differently about violence and to change their behavior accordingly." [21]

- Teams of OWs and VIs are supervised by higher-level program staff, who are kept informed about developments in the community, to help the overall program stay abreast of trends and potential future violence. During these communications, "[i]ndividuals in CV programs are described… using pseudonyms… to preserve their anonymity and their cooperation." The rest of the program staff work on changing social norms more diffusely. "The program does this using various activities, including public education campaigns that include signs and billboards, and community events such as anti-violence marches and post-shooting vigils. The CV program supports a wide range of activities that expose the community to effective anti-violence messages to build a general social consensus against violence."[22]

- *Outcomes:* CV programs attracted widespread attention after the implementation of the original CV model (initially called CeaseFire) in Southern and Southwestern Chicago neighborhoods. As a result, there are numerous empirical evaluations of the program. The **overall implications** of these programs are as follows:
  - The bulk of evidence available in CV evaluations suggests that the program is generally quite effective in reducing violence, especially in slowing increases in violence in implementation areas. Those decreases typically are measured through reductions in murders, aggravated assaults, shootings, or gun assaults. For example, in Baltimore, MD, a CV evaluation found that reductions in homicides ranged from insignificant to 56% reductions (based on the neighborhood in which the program was implemented).[23]
  - The most effective CV programs are well-targeted (within their respective communities) to optimize between needs and community resources. Next, deviation from the program structure can result in uneven and/or less effective implementation. Finally, a carefully designed evaluation is necessary to demonstrate program effectiveness and secure buy-in.
  - In each evaluation, the most successfully achieved outcome was shifting individual-level social attitudes and norms around violence, as measured with multi-wave surveys (surveys where individuals, or representative samples of communities are interviewed multiple times).

[21] (p.41)
[22] (p.41-42)
[23] (p.43-44)

- Effective implementation of the model is critical to its success. In each evaluation, there is site-by-site variation in effectiveness. There is no single CV program in which all of the sites targeted achieve a reduction in violence, or a slowed increase of violence. Qualitative evidence collected post-hoc suggests that these disparities are due to problems of implementation, or qualitative differences in the effectiveness of VI/OW teams/offices.
- The success, popularity, and prominence of CV programs often lead to jurisdictions co-opting the label of the CV model without adopting each component of the model. These programs were among the least successful. These two findings constitute the largest limitation to CV programs.

Hospital-Based Violence Interruption and Prevention Programs:

- Hospital-Based Violence Interruption and Prevention Programs (HVIPs) are a closely-related program designed to reduce individuals' probabilities of being subject to repeated violence. Like CV programs, HVIPs attempt to intervene immediately after (rather than before) to an act of intentional violence, to interrupt cycles of violence and retaliation. Advocates of HVIPs suggest that by using "family or group therapy, substance abuse treatment, and/or training in emotional regulation skills"[24] in the crucial moments just after a violent assault, that individuals might opt to further pursue such social resources, rather than opting to perpetuate cycles of violence. The breadth of services offered in the immediate aftermath of an assault varies, as does the assault that precipitates program action: evaluators emphasize that there "is no standard HVIP."[25] However, strong preliminary evaluations suggest that HVIPs are effective "in hospitals with significant rates of trauma and in areas where the cost of injury and recidivism are high… among violently injured patients."[26]
    - The theory undergirding HVIPs is relatively straightforward. HVIPs operate from the starting assumption that the moments just after an individual has suffered a violent injury that, due to demographic, contextual, and economic factors, are likely to be repeated, are "teachable moments."[27] Recent evidence has emphasized the importance, if not necessarily the opportunity for instruction, of

[24] (Affinati et al., 2016, p. 1-2)
[25] (p.2)
[26] (Nordeen, 2015,p.785).
[27] Other use more trivial language, including terming the moments just after violence "[the] 'golden hour'" (Cooper et al., 2006, p. 538). JAD feels that use of this terminology risks trivializing the near-death experiences of Harris County residents.

individuals' first violent victimization. Bonne *et al.* present evidence that subsequent violent victimizations are more lethal, and more expensive (2020), indicating the importance of breaking the "cycle of violence" earlier, rather than later.

- To implement that theory of change, "HVIPs combine brief in-hospital intervention with intensive community-based case management and provide targeted services to high-risk populations to reduce risk factors for re-injury and retaliation while cultivating protective factors."[28] Those practices work to direct potential participants' responses to traumatizing violence, helping connect participants to social services, and route them away from behaviors that could prompt additional violence or victimization.
    - Extensive evidence suggests that the participant pool of existing HVIPs has, overwhelmingly, tended to be "young [B]lack men."[29] Thus, the effectiveness of HVIPs has been predominately demonstrated in young, Black, and to a lesser extent, Latino men. There is less evidence of the program's effectiveness in women, or AAPI or white people. Research conducted into HVIPs often theorizes that the programs are particularly likely to be effective in young Black and Latino men, though without specifying why that would be the case.
        - Similarly, fully 75% of participants in some HVIPs have PTSD, and *all* participants in some HVIPs have some level of exposure to adverse events or treatment in childhood.[30] Evaluators do not, necessarily, conclude that HVIPs are particularly or exclusively effective in people with adverse childhood experiences or traumas. More plausibly, those experiences are prevalent amongst populations that disproportionately suffer violent victimization.
    - HVIPs connect individuals hospitalized with a violent injury to a variety of resources to break the cycle of violence. Most prominent are *case managers.*
        - Case managers provide "[s]trong therapeutic relationships" with program participants, and "are key to the success of HIVPs."[31] Unsurprisingly, case managers play similar roles to the OWs, and to a lesser extent, the VIs in a CV model. Like VIs, they are expected to have life experiences and backgrounds that will lend credibility to program participants. However, like OWs, they are

[28] (Purtle et al., 2013,p.331)
[29] (Bonne et al, 2020)
[30] (Corbin et al., 2013)
[31] (Decker et al., 2020, p.2).

expected to facilitate connections between program participants and constructive social resources like government services, employment opportunities, and alternative social networks. Despite their importance to HVIPs, the role of case managers is, to some extent, underdrawn in the scientific literature in HVIPs.

- Case managers are key to the success of HVIPs. Given this fact, researchers have traced the factors that make case managers effective. Decker *et al.*, after extensive interviews with participants in a prominent HVIP, argue that several distinct criteria can be identified: case managers must (1) "understand and relate to [participants'] sociocultural contexts," (2) create a connection with the participant at the initial, in-hospital meeting, (3) "exhibit true compassion and care," (4) "serve as role models," (5) "act as portals of opportunity"[32], and (6) "engender mutual respect and pride."[33] For each of these reasons, some evaluations of HVIPs frame the program as "peer intervention" programs.[34]

- The effectiveness of HVIPs is measured via their impacts on numerous different variables. HVIPs are most commonly associated with reducing victimization recidivism: for example, the probability that an individual hospitalized due to experiencing violent assault will be hospitalized for the same reason again within a given window of time. Slightly less commonly, research traces HVIPs' impact on the likelihood of later criminal offenses, especially violent offenses. Scholars have called for greater clarity about the core outcomes associated with HVIP participation. While scholars have posited substantial, additional effects—including numerous psychological and emotional benefits[35]—the overwhelming bulk of research into HVIPs emphasize behavioral changes around violence and victimization. The duration of those effects is far less clear: many evaluations identify effects ranging from six to twelve months after a participant's initial hospitalization. ***However, one***

[32] Specifically by replacing existing, destructive social networks with those that can provide constructive sources of income, pride, and "a way to stay busy." (Decker et al., 2020, p.12).
[33] (p.1).
[34] (Shibru et al., 2007)
[35] (Monopoli et al., 2018)

evaluation found that HVIPs positively effected violence recidivism up to 8 years after initial hospitalization.[36]

- Overall evaluations of HVIPs have yielded positive results. That said, a "systematic review" (like a meta-analysis that does not consolidate statistical evidence) of HVIPs found insufficient evidence to identify a consistent positive effect of the programs. This is partly due to the difficulty in identifying a comparison group of near-participants against which to evaluate the program's effects.[37] There are several primary pilot HVIPs,[38] evaluations of which JAD outlines below.
  - **Evaluations of HVIPs have presented evidence that the programs could, by reducing violence recidivism, increase the life expectancies of patients, to the tune of almost 26 Quality Adjusted Life Years per patient.**[39] Commensurate with the theory of HVIP success, in several prominent evaluations using diverse methodologies, more intensive case management (measured by more time spent on case management) was associated with more successful program outcomes.[40]
    - Of particular relevance to Harris County is the impact of HVIPs on violence recidivism. Researchers have, especially, found evidence that HVIP participants have low long-run recidivism rates, though the study in question appeared not to use a comparison group.[41] Studies with a comparison group presented similarly positive findings (see below). Most of these studies are *observational*: they estimate the program's effectiveness by comparing individuals or areas the program effected to a comparison individual or area that is very much like the program. In a rare randomized controlled trial (a classical experiment where individuals' admittance to the program is randomized) in Winnipeg, Manitoba, researchers could replicate consistent findings of reduced violence recidivism.[42] Generally speaking, a well-designed

[36] (Bell et al., 2017).
[37] (Affinati et al., 2016)
[38] (Dicker, 2016)
[39] (Juillard et al., 2015)
[40] (Aboutanos et al., 2011; Smith et al., 2013)
[41] (Bell et al., 2017).
[42] See: Snider et al. (2020). While research into the effectiveness of HVIPs is somewhat limited by the designs of these evaluations, given the weight of plausible observational studies identifying their effectiveness, it is reasonable to conclude

experimental study is preferable to a well-designed observational study, because an observational study may, accidentally, misclassify underlying differences in individuals or areas.[43] Frequently—as is the case in studies of political or policy variables—implementation of random assignment is not feasible or is unethical. This explains why the overwhelming majority of studies considered here are observational.

- As with the CV programs evaluated above, there is less consistent evidence of the impact of HVIPs on participants' attitudes. Researchers have studied the effect of HVIPs on attitudes via "questions on parenting, family, delinquency, stress, peer delinquency, future expectations, achievements, aspirations and values, and social competency."[44] Though these effects are less consistently studied, *there is evidence* (cited above) *that those effects persist years after the initial conversation with program staff.*
- While these analyses focus on the impact of HVIPs on violence and re-injury, researchers have also traced the influence of HVIPs on public health expenditures. HVIPs, broadly, have been demonstrated to reduce public health expenditures by reducing second hospitalizations, which are "$5,000 more expensive." These cost-savings[45] are also accomplished by reducing participants' risk of incipient loss of life.[46] Other estimates drawn from simulations suggest that the implementation of an HVIP could save up to $6,000 per patient.[47]

Best Practices:

- Violence interruption programs have the potential to generate meaningful reductions in violence and social norms around violence, while also "interrupting" the cycle of violence, which can lead to repeated victimization,

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that there are ethical reasons for evaluators not implementing randomized experiments.

[43] For example, if a beneficial policy intervention, like an eviction moratorium, was implemented in a CV implementation neighborhood, but not in the comparison group, the evaluation would estimate the combined effect of the two programs, rather than only the effectiveness of CV.

[44] (Zun et al., 2004, p.248)

[45] JAD notes that justifying reduced loss of life in Harris County residents in terms of a few thousand dollars saved is of far less importance than that program's actual effectiveness at saving lives and reducing traumatic reinjury rates.

[46] (Bonne et al., 2020)

[47] (Juillard et al., 2016)

provided that best program practices are adhered to. Deviating from best practices has presented challenges for some CV programs. Some of the particularly salient implications for Harris County are:

- *Producing a good evaluation*
  - The effect of these programs is strongly contingent on successful **implementation**: effects of the program were usually heterogeneous across implementation sites. In some cases, evaluators identified the program's positive effects by excluding sites with poor implementation from the evaluation. This is, categorically, not best practice: if barriers to implementation are barriers to program success, they should be studied, rather than dropped from analyses. Alternatively, if a properly implemented CV program would completely stop all violent crime in Harris County, but CV programs were nearly impossible to implement correctly, that should inform Harris County's decision regarding if/how to implement a CV program.
  - Identifying the effect of a CV program is strongly contingent upon the **choice of comparison jurisdictions**.[48] Because of this fact, JAD devoted substantial space in this report to the identification of a credible counterfactual location for the CV pilot program.
- *Evaluation of program's effect on attitudes*
  - Given that the CV program revolves around changing community attitudes around violence, gun-carrying, and retaliation, providing evidence for such attitude change is essential to validating CV's status as an evidence-based policy. **Identifying the effect of a CV pilot on attitude change, however, requires a comparison group**. In the absence of such a comparison group (ideally residing far away from the area in which CV is implemented), attributing attitudes (or even attitude change) in program participants to CV requires strong, even stereotypical assumptions about the target participation for CV. Thus, JAD maintains that the attitudes (not merely crime rates) of individuals residing in the comparison area must be identified with surveys as comprehensive as those implemented in the pilot area.
  - Furthermore, **identifying CV's ability to cause positive attitudes around violence, retaliation, and gun-carrying to diffuse throughout the community requires surveying the community at large, rather than simply the social cohorts CV targets**. Evidence that CV's effects were limited to young, potentially gang affiliated men with histories of involvement in the criminal justice system, would not—if all other effects were constructive—be evidence of

[48] (Roman et al., 2018)

the program's failure, but would indicate the need for *other* community messaging around violence prevention.

- The implementation of each of these programs requires close engagement with community resources. This research, especially when working to identify potential jurisdictions for implementing a CV program, prioritized considering administrative data tracking community-level disadvantage, to focus on the *need* for a CV program. Implementation of a successful program also requires the mobilization and use of community resources. Harris County has contracted with a consultant to identify key community resources with which a CV program could collaborate. **Those findings should be placed alongside the findings here to identify an implementation site.**

- Hospital-Based Violence Interventions
  - HVIPs appear less likely to have specific and idiosyncratic implementation difficulties, as is the case with some specific CV programs. That said, evaluators of HVIPs have shown that the programs can struggle to maintain contact with participants/potential participants (Affinati et al., 2016). This has two immediate implications for practice in Harris County, which are discussed here.
    - If HVIPs often lose contact with participants or individuals marked for a comparison group, it has strong implications for public health and for the quality of evaluations. Namely, **if the program is as effective as indicated in evaluations, the failure to closely monitor participants, and track them into community resources, necessary means that individuals that would benefit from HVIP treatment are not receiving the evaluation.**
    - Furthermore, HVIPs that have a weak track record at maintaining contact with program participants are likely reporting biased estimates of program participants. **It is, at the very least, a credible assumption that individuals the HVIP loses contact with will have a less marked response to the intervention than those who maintain close contact with HVIP staff**. If that is the case, each evaluation of HVIPs is—to some extent—biased in the direction of a positive effect of the program.

Conclusion:

- This evaluation has presented evidence that several closely-targeted policy interventions could reduce the probability that Harris Country residents at greatest risk of experiencing and perpetrating violence will continue.
- These interventions operate from a "public health perspective," that is, they work to direct these individuals toward social and community resources that might attenuate their risks of perpetration and victimization.

- Moreover, these programs adhere closely to the premise that individuals at risk of violence are especially persuaded by peers who can claim to represent participants' life experiences.
- These programs have, in several evaluations, been demonstrated to be effective. However, some minor analytical difficulties associated with evaluating both programs are most strongly related to the difficulty of accomplishing ethical random assignments with individuals at such risk and facing such entrenched vulnerability.
- The largest limitation of these analyses is that their highly-targeted, norms-focused approach attempts to intervene at "the last moment" before potential re-victimization or retaliation. Thus, these programs attempt to stop violence without changing the economic, social, and racial inequalities that cause violence.

Information on Program Feasibility

- This transmittal accompanies two reports on the feasibility of two pioneering programs that apply a public health approach to violence prevention: CureViolence and Hospital-Based Violence Intervention Programs. The Harris County Justice Administration Department, has collaborated with experts in implementing these programs to create reports that identify guidelines and best practices for implementation in Harris County. They are briefly discussed below.
    - Tillmon Training and Consulting produced a memo outlining best practices for implementation of a CureViolence-derived pilot program in Harris County. Tillmon *et al.*'s transmittal identifies broad trends in violence in Harris County, discusses neighborhoods where violence and community resources are sufficiently high to undergird a community violence intervention program, and discusses the structure and implementation of such a pilot in Harris County.
    - The Hospital Alliance for Violence Intervention produced a similar memo outlining best practices for implementation of a Hospital-Based Violence Intervention Program to apply a public health approach further. Fortin *et al.*'s transmittal identifies how trends in violence in Harris County intersect with health care providers and community assets.

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